An Information Service of the Division of Medical Assistance

North Carolina

Medicaid Pharmacy

Newsletter

Number 159 ***June 2008***

In This Issue...

Published by EDS, fiscal agent for the North Carolina Medicaid Program
1-800-688-6696 or 919-851-8888

Updated Prescription Advantage List

The Prescription Advantage List (PAL) has been updated and now includes an interactive tool and PAL Pocket Card. The PAL includes some of the most costly medications covered by the N.C. Medicaid Outpatient Pharmacy Program. The medications in each drug class listed on the PAL are ranked in order from least to most expensive and placed in a tier. The tier that a drug is placed in is based on an evaluation of the net cost per unit of the medication, including rebates. The tiers are calculated on a quartile distribution system utilizing all medications' net cost per unit in the drug class. The lowest cost medications are tier 1 medications and the most expensive medications are tier 4 medications. The PAL is intended as an educational tool based on cost alone; no judgment as to the efficacy is implied.

Medications listed on the PAL Pocket Card were identified using more stringent criteria than the tier methodology. The following criteria had to be met for the drug to be on the PAL Pocket Card:

- The drug was identified as a drug or drug class commonly prescribed by N.C. Medicaid prescribers.
- The drugs are in a drug class with a significant price differential between drugs based on cost analysis from the most recent quarter available and a review of six (6) to nine (9) months of prior data.
- Evidence exists to compare efficacy and safety between the drugs in the class, as well as in clinical trials, with head-to-head comparisons of drugs within the class when available.

The PAL and the PAL Pocket Card can be found on DMA's website at http://www.ncdhhs.gov/dma/pharmacy.htm and on the N.C. Physicians Advisory Group website at http://www.ncpag.org.

New Prior Authorization Program for Brand-Name Schedule II Narcotics

On August 4, 2008, the N.C. Medicaid Outpatient Pharmacy Program will implement a new prior authorization (PA) program for brand-name schedule II (CII) narcotics. On this date, pharmacists may receive a point-of-sale message that PA is required for brand-name prescriptions in this drug class. Brand-name short-acting and long-acting CII narcotics will require PA. This PA program will replace the current Oxycontin PA program. PA will not be required for recipients with a diagnosis of pain secondary to cancer.

If a pharmacy provider receives a point-of-sale message that PA is required, the prescriber may contact ACS at 866-246-8505 (telephone) or 866-246-8507 (fax) to request PA for these medications. The PA criteria and request form for brand-name narcotics will be available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

If the PA is approved and a brand-name narcotic medication is dispensed when a generic version is available, "medically necessary" must be written on the face of the prescription in the prescriber's own handwriting.

Prescribing clinicians are encouraged to review the N.C. Medical Board's statement on use of controlled substances for the treatment of pain when prescribing narcotics. This statement may be found at http://www.ncmedboard.org/Clients/NCBOM/Public/NewsandForum/mgmt.htm.

Pharmacies Participating in the 340b Program

If your pharmacy is eligible to participate in 340b**,** you must submit a request to participate to the Office of Pharmacy Affairs (OPA) with your Medicaid billing information and the appropriate form. The website is http://www.hrsa.gov/opa/introduction.htm and the form is listed at the following link ftp://ftp.hrsa.gov/bphc/pdf/opa/PrgmReg.pdf

It is very important that OPA have information that is accurate and up to date, particularly the covered entity's exact name and street address. It is the responsibility of each covered entity to contact the OPA with any changes.

While the entity is eligible to participate in the program by virtue of its status, it must notify the OPA of its intention to participate by completing and submitting the appropriate registration form. Once the OPA receives this information, the entity will be eligible to receive pharmaceuticals at the 340B discounted price at the beginning of the next calendar quarter. The quarterly deadlines for data submission to OPA are December 1 for the quarter beginning January 1; March 1 for the quarter beginning April 1; June 1 for the quarter beginning July 1; and September 1 for the quarter beginning October 1**.** It is the entity's responsibility to tell its wholesaler or manufacturer that it is registered for 340B discount prices when it places an order.

If you have any questions regarding this program, please call the HRSA Pharmacy Services Support Center at 800-628-6297.

It is also important that you notify NC Medicaid of your intent to participate. While the presence of the Medicaid provider number on OPA's database indicates eligibility to participate, the exact quarter of purchasing is required in order to ensure that the state coordinates the exclusion of claims for rebate processing. Please contact Sharon Greeson with the EDS Pharmacy Department at 800-688-6696 and notify her of your intent to start participating.

Any provider purchasing drugs through the 340b program is required to bill Medicaid the actual acquisition cost plus the dispensing fee (unless they are keeping a separate stock for Medicaid). This is reviewed through a post payment review and overbillings are subject to recoupment

National Provider Identifier Customer Support

N.C. Medicaid has taken proactive steps to ensure that when National Provider Identifiers (NPIs) are implemented on May 23, 2008, providers continue to receive reimbursement for services rendered to N.C. Medicaid recipients. DMA and EDS staff have received training to ensure they are able to address provider inquiries related to NPI. An NPI unit has been added to the EDS Provider Services team to handle NPI phone calls and research NPI issues. Callers will hear an option for the NPI Help Desk when contacting EDS Provider Services (1-800-688-6696 or 919-851-8888).

In addition, beginning June 9, 2008, the hours of operation for the EDS Provider Services Call Center will be extended to 5:30 p.m. This expansion of hours will be provided on a temporary basis to assist with additional NPI-related calls.

How National Provider Identifier Implementation Will Affect Remittance and Status Reports

Beginning with the first checkwrite following the implementation of National Provider Identifiers (NPIs) on May 23, 2008, only the NPI will be reported on the 835 electronic remittance advice (ERA). Since Medicaid will still be processing and paying claims based on the Medicaid Provider Number (MPN), providers may receive multiple 835 ERAs, depending on the number of MPNs for which claims were processed. A separate 835 ERA will be sent for each MPN but only the NPI will be listed on the 835 ERA.

The paper RA was modified in January to include both the NPI and the MPN.

Individuals with Multiple Provider Numbers

DMA has identified a number of individual providers with more than one Medicaid Provider Number (MPN) for the specific service they are enrolled to provide. (For example, an individual physician employed by a physician group with more than one site using one Medicaid Provider Number to bill for services provided at one site and a second Medicaid Provider Number to bill for services provided at the second site.)

Effective August 1, 2008, all individual providers will be required to maintain one service-specific MPN to ensure that claims process correctly when billing with National Provider Identifiers. DMA will end-date all but one of the provider's MPNs.

Individual providers who have been identified as having more than one service-specific MPN will be notified by mail 30 days prior to this administrative action. The letter will inform the individual provider that all previously assigned MPNs will be end-dated and will identify the MPN that is assigned to the provider for the service he or she is enrolled to provide.
Please note that the requirement to maintain one MPN does not apply to an individual provider who is enrolled with Medicaid to provide services in more than one program area. (For example, a psychiatrist who is also enrolled as a licensed psychologist providing services as an outpatient mental health practitioner.) Nor does the requirement apply to group providers, such as a home health agency that is enrolled with N.C. Medicaid as a home health provider and a Community Alternatives Program provider. In these cases, the provider must maintain each MPN that is specific to the services they are enrolled to provide.

Please note that the requirement to maintain one MPN does not apply to an individual provider who is enrolled with Medicaid to provide services in more than one program area. (For example, a psychiatrist who is also enrolled as a licensed psychologist providing services as an outpatient mental health practitioner.) Nor does the requirement apply to group providers, such as a home health agency that is enrolled with N.C. Medicaid as a home health provider and a Community Alternatives Program provider. In these cases, the provider must maintain each MPN that is specific to the services they are enrolled to provide.

National Provider Identifier/Medicaid Provider Number Mismatch

Analysis has found that some providers are submitting a different National Provider Identifier (NPI) on claims than what was reported to DMA for their Medicaid Provider Number (MPN). Once providers no longer submit claims with the MPN, claims will process based on the NPI reported for the MPN(s) in the provider database. Therefore, it is imperative that providers use the same NPI on claims.

To troubleshoot, providers can verify that the correct NPI(s) are on file by searching the NPI and Address Database (http://www.ncdhhs.gov/dma/WebNPI/default.htm). Search by NPI and MPN to ensure that each MPN has a corresponding NPI on file. Also, verify with vendors and clearinghouses that the correct NPI is being submitted on claims.

To update or change an NPI on file with DMA, print the correction form from the NPI and Address Database (http://www.ncdhhs.gov/dma/WebNPI/default.htm), make the appropriate change, and fax the form to DMA Provider Services. Allow two weeks for updates to be processed.

Clinical Coverage Policies

The following new or amended policies are now available on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm:

General Clinical Policy A2, Over-the-Counter Medications (5/9/08)

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

Early and Periodic Screening, Diagnostic and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows. EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): http://www.ncdhhs.gov/dma/medbillcaguide.htm.
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck.htm.
- EPSDT provider information: http://www.ncdhhs.gov/dma/EPSDTprovider.htm.

Changes in Drug Rebate Manufacturer

The following change has been made in manufacturers with Drug Rebate Agreements. It is listed by manufacturer code, which is the first five digits of the NDC.

Additions

The following labeler has entered into Drug Rebate Agreements and has joined the rebate program effective on the dates indicated below:

Code	***Manufacturer***	***Date***
24486	Aristos Pharmaceuticals, Inc.	06/09/2008

Checkwrite Schedule

June 10, 2008	July 10, 2008	August 12, 2008
June 17, 2008	July 17, 2008	August 19, 2008
June 26, 2008	July 26, 2008	August 28, 2008
June 10, 2008		

Electronic Cut-Off Schedule

June 05, 2008	July 05, 2008	August 07, 2008
June 12, 2008	July 12, 2008	August 14, 2008
June 15, 2008	July 15, 2008	August 21, 2008
June 19, 2008	July 19, 2008	

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS claims must be transmitted and completed by 12:00 midnight on the day of the electronic cut-off date to be included in the next checkwrite.

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